GESSEL ORTHODONTICS

Dr. Thomas Gessel
1628 South Mildred
Tacoma, WA 98465
(253) 503-1023

Thank you for selecting our orthodontic health care team! We will strive to provide you with the best possible orthodontic care. To help us meet all of your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION – Please Print (Confidential)

Name: _____ _____ Gender: __ Male __ Female
First Middle Last Nickname

Age: _____ Date of Birth: ____/____/____ Home Phone: (____) _____ Cell/Mobile Phone: (____) _____

Home Address: _____ City: _____ Zip: _____ E-mail: _____

Patient's School: _____ Grade: _____ Hobbies: _____

Person to Contact in Case of Emergency: _____ Relationship: _____ Phone: (____) _____

Name of Dentist: _____ Address: _____ City: _____ Zip: _____

How long has he/she been a patient at above: _____ Date of Last Dental Check-up: _____

Referred By: __Friend: _____ __ Dentist __Yellow Pages __ Other: _____

Does the patient play a musical instrument?_____ Engage in contact sports?_____

Has patient had any previous orthodontic treatment or orthodontic consultations? __Yes __No If yes, when? _____

If so, where?_____ What were you told?_____

What is/are main concern(s) about the patient's teeth? _____

FAMILY INFORMATION

Father's Name:_____ Address: _____ City: _____ State:___ Zip:_____

Father's Employer:_____ Occupation: _____ Work Phone: (____) _____

Home Phone: (____) _____ Mobile/Cell Phone: (____) _____ Email Address: _____

Mother's Name: _____ Address: _____ City: _____ State:___ Zip:_____

Mother's Employer:_____ Occupation:_____ Work Phone: (____) _____

Home Phone: (____) _____ Mobile/Cell Phone: (____) _____ Email Address: _____

Have any family members been previously treated at our offices: __Yes __No Names/Offices: _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address: _____ City: _____ State:___ Zip: _____ Phone: (____) _____

Driver's License # : _____ Date of Birth: ____/____/____ SSN: ____-____-____

Employer: _____ Address: _____ Phone: (____) _____

INSURANCE INFORMATION

Does patient have Orthodontic Insurance coverage? __Yes __No __ Not Sure

If yes, Name of Insured: _____ Date of Birth: ____/____/____ SSN of Insured: ____-____-____

Insurance Company Carrying Policy: _____ Group#:_____ Union or Local #:_____

Name of Insured (Secondary): _____ Date of Birth: ____/____/____ SSN of Insured: ____-____-____

Insurance Company Carrying Policy:_____ Group#: _____ Union or Local #:_____

Please bring your insurance information to the office at your first visit.

PATIENT MEDICAL HISTORY

Physician: _____ Office Phone: (____) _____ Date of Last Exam: ____/____/____

	Yes	No
1. Is patient under medical treatment now?	__	__
2. Has patient ever been hospitalized for any surgical operation or serious illness within the last 5 years?	__	__

If yes, please explain: _____

_____

3. Is patient taking any medication(s) including non-prescription medicine?	__	__

If yes, please list: _____

_____

4. Has patient ever taken Phen-Fen/Redux?	__	__
5. Does patient use tobacco?	__	__
6. Does patient use controlled substances?	__	__
7. Is patient wearing contact lenses?	__	__

8. Is patient allergic to or have they had any reaction to the following:

	Yes	No
Local anesthetic (e.g. Novocaine)	__	__
Penicillin or any Antibiotics	__	__
Sulfa Drugs	__	__
Barbiturates	__	__
Sedatives	__	__
Iodine	__	__
Aspirin	__	__
Any Metals (e.g. nickel, mercury, etc.)	__	__
Latex Rubber	__	__
Other (please list): _____		

9. Women only:

a) Is patient pregnant or think she may be pregnant?	__	__
b) Is patient taking oral contraceptives?	__	__

Does patient have or have they had any of the following:

	Yes	No		Yes	No		Yes	No
High Blood Pressure	__	__	Heart Disease	__	__	Chest Pains	__	__
Heart Attack	__	__	Cardiac Pacemaker	__	__	Easily Winded	__	__
Rheumatic Fever	__	__	Heart Murmur	__	__	Stroke	__	__
Swollen Ankles	__	__	Angina	__	__	Hay Fever/Allergies	__	__
Fainting/Seizures	__	__	Frequently Tired	__	__	Tuberculosis	__	__
Asthma	__	__	Anemia	__	__	Radiation Therapy	__	__
Low Blood Pressure	__	__	Emphysema	__	__	Glaucoma	__	__
Epilepsy/Convulsions	__	__	Cancer	__	__	Recent Weight Loss	__	__
Leukemia	__	__	Arthritis	__	__	Liver Disease	__	__
Diabetes	__	__	Joint Replacement or Implant	__	__	Heart Trouble	__	__
Kidney Diseases	__	__	Hepatitis/Jaundice	__	__	Respiratory Problems	__	__
Aids or HIV Infections	__	__	Sexually Transmitted Disease	__	__	Mitral Valve Prolapse	__	__
Thyroid Problem	__	__	Stomach Troubles/Ulcers	__	__	Other: _____		

PATIENT DENTAL HISTORY

Name of patient's dentist and location: _____ Date of Last Exam: ____/____/____

	Yes	No
1. Do patient's gums bleed while brushing or flossing?	__	__
2. Are teeth sensitive to hot or cold liquids/foods?	__	__
3. Are teeth sensitive to sweet or sour liquids/foods?	__	__
4. Does patient feel pain to any teeth?	__	__
5. Has patient had any sores or lumps in or near mouth?	__	__
6. Has patient had any head, neck or jaw injuries?	__	__
7. Has patient ever experienced any of the following problems with their jaw:		
a) Clicking	__	__
b) Pain [joint, ear, side of face]	__	__
c) Difficulty in opening or closing	__	__
d) Difficulty in chewing	__	__

	Yes	No
8. Does patient have frequent headaches?	__	__
9. Does patient clench or grind teeth?	__	__
10. Does patient bite lips or cheeks frequently?	__	__
11. Has patient ever had difficult extractions?	__	__
12. Has patient ever had any prolonged bleeding?	__	__
13. Has patient ever had any orthodontic treatment?	__	__
14. Does patient require antibiotics for dental treatment?	__	__
15. Has patient ever received oral hygiene instructions regarding care of teeth/gums?	__	__

16. What are chief orthodontic (dental) concerns(s)?

_____

_____

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to patient's health. I authorize Gessel Orthodontics to release any information including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Gessel Orthodontics any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

X _____ Relationship to Patient

Signature of Patient/Responsible Party

Doctor's Comments: _____

_____

Signature: Date: